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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10768
CERTIFICATE OF DEATH10770337
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 636 Dover St	
3. NAME OF DECEASED (Type or print) First AVERY Middle CARLTON Last ADKINS		4. DATE OF DEATH Month OCT. Day 10 Year th 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee - Laborer (Swanson & Campbell Co.)		10b. KIND OF BUSINESS OR INDUSTRY R.D. # 3 Salisbury, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Annie M. Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. Lillian P. Adkins (Wife)		Address 636 Dover St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema 434.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic cor pulmonale. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-11 , 19 54 , to 10-10 , 19 56 , that I last saw the deceased alive on 10-10 , 19 56 , and that death occurred at 3:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 211 Maryland Ave. (Office) Oct. 12 1956 DATE SIGNED ACTUAL SIGNATURE AC Mitchell M.D. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1956	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR 15 1956 DATE 24b. REGISTRAR'S SIGNATURE Mary V. Holloway	

BUREAU V. S.

15. 51. 100.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG206 11-2-56 et

10771

CERTIFICATE OF DEATH

Reg. Dist. No. 332

10769

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Thurston</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ocean City</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General</u>				STREET ADDRESS (If rural give location) <u>7</u>			
3. NAME OF DECEASED (Type or Print) <u>CLARENCE</u> (First) <u>E</u> (Middle) <u>ADKINS</u> (Last)				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>24</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 10 1879</u>		9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>V.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jehu Adkins</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>How. Adkins, Ocean City, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/19/56</u> to <u>10/29/56</u> 1956 , that I last saw the deceased alive on <u>10/29/56</u> , and that death occurred at <u>10/29/56</u> M , from the causes and on the date stated above.							
SIGNATURE <u>W. R. Ellis</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>10-25-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>GREENBACKVILLE</u>		LOCATION (City, town, or county) (State) <u>GREENBACKVILLE VA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Hallway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. N. A. Shields</u>		ADDRESS <u>New Church</u>	
DATE <u>10/29/56</u>							

CERTIFICATE OF DEATH

Reg. No. 120

IF DEATH OCCURRED AT HOME, RECORD HERE

NAME OF DECEASED

George W. H. H.

RESIDENT OF

City

Peninsula General

Age

Chances

White

M

Hicks

10 24

Central Telephone

10000

BUREAU V. E.

10/19/56

Oct 30 1956

RECEIVED

10/19/56

INSTRUCTIONS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13034

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY <u>BRONX, N.Y.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>8 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRONX, N.Y.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hosp.</u>				d. STREET ADDRESS <u>517 Linton Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Ahern</u> Last <u>Ahern</u>				4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-37</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Jas Ahern</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>U.S. NAVY RECORDS, WASH., D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>			
20c. TIME OF INJURY Hour <u>12:15</u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>10-7-1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10-7-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Portsmouth, Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Marshall</u> ADDRESS <u>Derry-Twiford Funeral Home, Norfolk, Va</u>				24a. REC'D BY REGISTRAR <u>DATE 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>	

03 AUG 78

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10772

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Penna. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospt.				d. STREET ADDRESS Ontario Street, 1905			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sidney Middle P. Last Anderton				4. DATE OF DEATH Month Oct. Day 22. Year 19 56.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22. 1909	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 11 Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Supervisor Westing House Elect. Co. Providence, R.I.				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) U.S. A.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Sidney A. Anderton				14. MOTHER'S MAIDEN NAME Clara G. Pollard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War # 2				16. SOCIAL SECURITY NO. 166_07__0751			
17. INFORMANT Mrs. Dorothy Anderton Brown (Sister)				Address 1905 Ontario, St. Phila. 34. Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause lost. 				INTERVAL BETWEEN ONSET AND DEATH 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-23-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26. 56.		22c. NAME OF CEMETERY OR CREMATORY Providence Cemetery.		22d. LOCATION (City, town, or county) (State) Providence, R.I.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.				24. REC'D BY REGISTRAR 21-155			
ADDRESS				25. REGISTRAR'S SIGNATURE Mary H. Holloway			
				DATE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		Jan 15, 1956	
Place of Birth		Residence		Occupation		Cause of Death		Manner of Death	
New York City		123 Main St, Baltimore		Teacher		Heart Disease		Natural	
Date of Birth		Date of Death		Time of Death		Place of Death		Signature of Examiner	
Jan 1, 1911		Jan 15, 1956		10:00 AM		Home		[Signature]	
Medical History		Family History		Social History		Autopsy		Remarks	
Hypertension, Diabetes		None		Smoker, 20 years		No		None	
Previous Illnesses		Previous Operations		Previous Injuries		Previous Accidents		Previous Deaths	
None		None		None		None		None	
Physician's Name		Physician's Address		Physician's Phone		Physician's Signature		Physician's Title	
Dr. Smith		456 Oak St, Baltimore		555-1234		[Signature]		M.D.	
Coroner's Name		Coroner's Address		Coroner's Phone		Coroner's Signature		Coroner's Title	
Mr. Jones		789 Pine St, Baltimore		555-5678		[Signature]		Coroner	

BUREAU V. 3

JAN 24 1956

RECEIVED

RECEIVED
 JAN 24 1956
 BALTIMORE, MD.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10773

10772 CERTIFICATE OF DEATH

Item 3 Film G295 10/22/66 go.

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>VIRGINIA</u>		COUNTY <u>ACCOMACK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>SALISBURY</u>		<u>6 1/2 hours.</u>		TOWN <u>ONANCOCK</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>8 KERR ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM E. BELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>OCTOBER 3 19 56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4-24-1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hornet & leather retailer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert F. Bell</u>				14. MOTHER'S MAIDEN NAME <u>Susan Savage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Deputy Laurence - Smithfield</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Myocardial infarct, acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>DUE TO</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u> <u>at work</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M., from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>				DATE SIGNED <u>10-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				NAME OF CEMETERY OR CREMATORY <u>ONANCOCK</u>		LOCATION (City, town, or county) <u>ONANCOCK, Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Perlish M. Williams</u>		ADDRESS	
DATE <u>10-6-56</u>							

3.14

Robert J. Bee
Hornes & Leach, Station

Very Truly Yours
Jesse H. Hodge

BUREAU V. F.

OCT 9 1956

RECEIVED

10-6-2 CHANCOCK
DANFORTH, W.
POLLARD, L. WILLIAMSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10774

Reg. Dist. No. 332

10773

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Noah</u> Middle <u></u> Last <u>Boone</u>		4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5, 1938</u>
9. AGE (In years last birthday) <u>28</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>230-22-0633</u>	
17. INFORMANT <u>Blanch Drake</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of the aorta</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by brother during a quarrel.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1 P</u> a. m. <u>10</u> p. m. <u>7</u> <u>19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>10-15-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 14-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brown Here Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barker M West</u>		ADDRESS <u>Salisbury</u>	
24a. REC'D BY REGISTRAR <u>Mary W Holloway</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W Holloway</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 100-10-10-10

DATE OF DEATH

PLACE

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

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UNDERLYING CAUSE OF DEATH

BUREAU V. 3

OCT 18 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

337

10804

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>		c. LENGTH OF STAY IN lb <u>24 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #2</u>				d. STREET ADDRESS <u>R F D #2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Anne</u> Last <u>Bounds</u>				4. DATE OF DEATH Month <u>11</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1913</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>31</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lunch room</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George William Bounds</u>				14. MOTHER'S MAIDEN NAME <u>Belle Taylor</u> <u>(Mrs. George William Bounds)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-36-0548</u>		17. INFORMANT Address <u>Mother-Mrs. George Bounds - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>973.1</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hose connected to exhaust pipe.</u>					
20c. TIME OF INJURY Month, Day, Year <u>12 Noon</u> <u>10-31-56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u>		20f. (City or town) <u>Eden</u>	(County) <u>Wicomico</u>	(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-2-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/3/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>George C. Hill</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Thos. H. Hallen</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10805
CERTIFICATE OF DEATH

10776
332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bradford</u> <u>Bradshaw</u>		4. DATE OF DEATH Month Day Year <u>Oct.</u> <u>22</u> <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1889</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Month Day Hours Min. <u>11</u> <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commerical</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Bradshaw</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Elzey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24-2493</u>	
17. INFORMANT <u>William Bradshaw, Nanticoke, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>10 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 May</u> , 19 <u>47</u> to <u>22 Oct.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 Oct.</u> , 19 <u>56</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D. ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u> DATE SIGNED <u>10/23/56</u> PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u> <u>Nanticoke, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick</u>		ADDRESS <u>Bivalve, Maryland</u>	
24a. REC'D BY REGISTRAR <u>OCT 29 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10777

10774

CERTIFICATE OF DEATH

Reg. Dist. No. 33r

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>2 WEEKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>POCOMOKE</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>RURAL #1</u>			
3. NAME OF DECEASED (Type or Print) <u>Leonard W. Brittingham</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 16 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov 17, 1903</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POULTRY</u>		11. BIRTHPLACE (State or foreign country) <u>SALLIE BEAUCHAMP U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>BERT BRITTINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>MARYLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-01-8875</u>		17. INFORMANT & ADDRESS <u>MRS LILLIAN B. BRITTINGHAM</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>ROBT. POCOMOKE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
416X IMMEDIATE CAUSE (A) <u>Bacterial Endocarditis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/27/56</u> , 19 <u>56</u> , to <u>10/16/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/16/56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. SIGNATURE <u>David J. Gilmore</u> M.D. <u>Salisbury Md Oct. 16, 1956</u> DATE SIGNED ADDRESS (Street, city, town, state) (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>OCT 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>BAPTIST CEMETERY</u>		LOCATION (City, town, or county) (State) <u>POCOMOKE, MD.</u>	
24. REC'D BY REGISTRAR <u>OT 19 1956</u>		REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke Md.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10778

10775

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>70 yrs</u>		TOWN <u>Seaford</u> #R.R. 3. <u>46X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>SPENCER</u> (First) <u>CALLOWAY</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-28-1886</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Mainland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Calloway</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Mae Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>26-14-2582</u>		17. INFORMANT & ADDRESS <u>Amelia Calloway - Seaford</u> RZ1043			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
162X IMMEDIATE CAUSE (A) <u>Rupture of pulmonary artery into bronchus</u>						<u>15 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Lung Abscess</u>						<u>3-6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Bronchogenic Carcinoma</u>						<u>> 6 mos.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/3</u> , 19 <u>56</u> , to <u>6/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>56</u> , and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. H. Gardner, Jr.</u> M.D.		ADDRESS (Street, city, town, state) <u>3215 D. U. St. Salisbury, Md.</u>		DATE SIGNED <u>10/4/56</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10-7-56</u>	NAME OF CEMETERY OR CREMATORY <u>Salisbury</u>		LOCATION (City, town, or county) <u>Salisbury, Md.</u>			
24. REC'D BY REGISTRAR <u>Mary H. Calloway</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Morn</u>		ADDRESS <u>Shaytown</u>			
DATE <u>OCT 11 1956</u>							

CERTIFICATE OF DEATH

REG. NO. 100

1. NAME OF DECEASED

WILLIAM HENRY BROWN

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. PREVIOUS ILLNESS

13. MEDICAL ATTENDANCE

14. SIGNATURE OF PHYSICIAN

BUREAU V. R.

OCT 11 1956

RECEIVED

REC'D

NOTED

This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, within ten days of the date of death. A copy of this certificate is to be furnished to the family of the deceased and to the funeral home. The certificate is to be signed by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, within ten days of the date of death. A copy of this certificate is to be furnished to the family of the deceased and to the funeral home.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

10776 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10779

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 22 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reids Grove		
d. NAME OF HOSPITAL (If not in hospital, give street address) Deer's Head State Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle Camper Last Camper			4. DATE OF DEATH Month October Day 19 Year 19 56		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1889		9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME No data			14. MOTHER'S MAIDEN NAME Mary Ida Stanley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Chronic 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Glomerulonephritis, chronic DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive arteriosclerotic cardiovascular disease					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 27 , 19 56 , to Oct. 19 , 19 56 , that I last saw the deceased alive on Oct. 18 , 19 56 , and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 10/19/56 ACTUAL SIGNATURE Dr. Juerman M.D. PHYSICIAN'S NAME (Type) V. Juerman, M. D. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1956	22c. NAME OF CEMETERY OR CREMATORY Reid's Grove Cemetery		22d. LOCATION (City, town, or county) (State) Reid's Grove, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland			24a. REC'D BY REGISTRAR DATE 10/24/56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
WILLIAM		M		30		1925		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Carpenter		High School		Married		Catholic		White		White		Brown		Blue	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		SECOND	
Heart Disease		Natural		Home		10/25/55		10:00		10:00		10:00		10:00	
Physician		Physician		Physician		Physician		Physician		Physician		Physician		Physician	
Signature		Signature		Signature		Signature		Signature		Signature		Signature		Signature	
Name		Name		Name		Name		Name		Name		Name		Name	
Address		Address		Address		Address		Address		Address		Address		Address	
City		City		City		City		City		City		City		City	
State		State		State		State		State		State		State		State	
Country		Country		Country		Country		Country		Country		Country		Country	
Signature		Signature		Signature		Signature		Signature		Signature		Signature		Signature	
Name		Name		Name		Name		Name		Name		Name		Name	
Address		Address		Address		Address		Address		Address		Address		Address	
City		City		City		City		City		City		City		City	
State		State		State		State		State		State		State		State	
Country		Country		Country		Country		Country		Country		Country		Country	

RECEIVED
OCT 29 1956
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 yr. 11 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS High Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arlie Middle - Last Collison				4. DATE OF DEATH Month October Day 12 , Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28, 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Collison				14. MOTHER'S MAIDEN NAME --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 220-0909851		17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism (recurrent) 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 465X DUE TO (c) 465X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9049 Fracture of the left femur							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 4 , 19 54 , to October 12 , 19 56 , that I last saw the deceased alive on October 12 , 19 56 , and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 10/12/56 ACTUAL SIGNATURE L.V. Maldve M.D. L.V. Maldve, M.D. PHYSICIAN'S NAME (Type) L.V. Maldve							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Oct 17				22b. DATE THEREOF Oct 17			
22c. NAME OF CEMETERY OR CREMATORY Denton				22d. LOCATION (City, town, or county) (State) Denton Md			
23. FUNERAL DIRECTOR'S SIGNATURE J.V. Moorhead Son				24. REC'D BY REGISTRAR DATE 10/17/56			
24b. REGISTRAR'S SIGNATURE May W. Holloway							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10781

10806

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Jesterville</u>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>C.</u> Last <u>Conway</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/1874</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Conway</u>				14. MOTHER'S MAIDEN NAME <u>Esther -----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>George Conway, Jesterville, Maryland</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>21 June, 1948, to 12 Oct. 1956</u> , that I last saw the deceased alive on <u>12 Oct. 1956</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D. <u>Nanticoke Md.</u>				DATE SIGNED <u>10/12/56</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				Address <u>Nanticoke, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Jesterville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cornelius J. Smith</u> ADDRESS <u>Bivalve, Maryland</u>				24a. REC'D BY REGISTRAR <u>Oct 18 1956</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

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BUREAU A. G.

OCT 18 1956

RECEIVED

10807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLARDS</u>				c. LENGTH OF STAY IN 1b <u>49 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>WILLARDS</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>SMITH</u> Last <u>COOPER</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 10, 1906</u>	
				9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE SALESMAN TRUCK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WILLARDS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GORDON LEE COOPER</u>				14. MOTHER'S MAIDEN NAME <u>IDA FLORENCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MR. GORDON L. COOPER WILLARDS MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>unknown</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 15, 1956</u> , to <u>Oct. 10, 1956</u> , that I last saw the deceased alive on <u>Oct. 10</u> , 19 <u>56</u> , and that death occurred at <u>1045 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Chas. R. Law</u> M.D. <u>Berlin</u>				<u>Oct-12-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WILLARDS</u>		22d. LOCATION (City, town, or county) (State) <u>WILLARDS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bruno R. Burbage Berlin Md</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE 15 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. The text appears to be a continuation of a report or a list of cases, with some words like "Name", "Age", "Sex", "Race", "Occupation", "Cause of Death", and "Date of Death" discernible.]

BUREAU V. 31

OCT 15 1936

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10783

CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> STREET ADDRESS (If rural give location) <u>304 Delaware Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William James Cottman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10 - 14 19 56</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>A. A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-10-1906</u>	9. AGE last birthday <u>50 yrs.</u>	IF UNDER 1 YEAR Months Days <u>4 4</u>	IF UNDER 24 HRS. Hours Min. <u>4 4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Wicomico Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Cottman</u>				14. MOTHER'S MAIDEN NAME <u>Annie Christopher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>163-16-3014</u>		17. INFORMANT & ADDRESS <u>Salisbury, Md.</u> <u>Mrs. Annie Cottman, 304 Del. Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 502.1 IMMEDIATE CAUSE (A) <u>Bronchiectasis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Bronchitis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Indeterminate</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13th Oct. 1956</u> to <u>14th Oct. 1956</u> , that I last saw the deceased alive on <u>14th Oct. 1956</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>6520 Main</u>		ADDRESS (Street, city, town, state) <u>Salisbury, Wicomico Co., Md.</u>		DATE SIGNED <u>12/16 Oct 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10-17-56</u>	NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co., Md.</u>			
24. REG'D BY REGISTRAR <u>Oct 19 1956</u>	REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>					

OCT 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10808

CERTIFICATE OF DEATH

10784

Reg. Dist. No. 387

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>				c. LENGTH OF STAY IN 1b <u>70 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>400 State Street</u>				d. STREET ADDRESS <u>400 State Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Virginia</u> Last <u>Culver</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Burton McCates</u>		14. MOTHER'S MAIDEN NAME <u>Letetia Hearn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs James B. Hearn, Delmar, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, peritoneal, liver</u> DUE TO (b) _____ DUE TO (c) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis or metastases</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>1/1</u> , 19 <u>53</u> , to <u>death</u> , 19____, that I last saw the deceased alive on <u>10/5</u> , 19 <u>56</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest M. Lamm</u> M.D.				ADDRESS (Street, city or town, state) <u>Delmar, Del</u>		DATE SIGNED <u>10/8/56</u>	
PHYSICIAN'S NAME (Type) _____				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>10-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar, Delaware</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. S. Marvel Co - Delmar, Del</u>				24a. REC'D BY REGISTRAR <u>DATE 11 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		40		M		W		1885		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1910		BALTIMORE		BALTIMORE		MARYLAND		OCT 11 1956		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SPECIAL INSTRUCTIONS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST							
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
OCT 11 1956		BALTIMORE		BALTIMORE		MARYLAND		OCT 11 1956		BALTIMORE		BALTIMORE		MARYLAND	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	

BUREAU V. S.

OCT 11 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 FilmG206 11-7-56 et

CERTIFICATE OF DEATH

10785

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>SOMERSET</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>SALISBURY</u>	<u>12 DAYS</u>	TOWN <u>CHANCE</u>	<u>19X. 2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
<u>PENINSULA GENERAL HOSPITAL</u>			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>GREELY</u> (Middle) <u>DASHIELL</u> (Last)		(Month) <u>OCTOBER</u> (Day) <u>27</u> (Year) <u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, (MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>Approx. 84 yrs.</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
<u>Housewife & farmer</u>		<u>Ind</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Edgar Washell</u>		<u>Elizabeth Webster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>220-09-1747</u>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>Lulu Washell Chance Ind</u>		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>610X IMMEDIATE CAUSE (A) <u>Acute pulmonary edema</u></u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>Antecedent Cause(S) DUE TO (B) <u>Arteriosclerotic C-v disease</u></u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Benign prostatic hypertrophy.</u>	
19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>10-19-56</u>		<u>Benign prostatic hypertrophy</u>	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>		<input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work	
<u>M.</u>		<u>21f. HOW DID INJURY OCCUR?</u>	
22. I hereby certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>William H. Ashby M.D.</u>		<u>10-27-56</u>	
23. BURIAL, CREMATION REMOVAL (SPECIFY)		23. FUNERAL DIRECTOR'S SIGNATURE	
<u>Buried</u>		<u>James Herman Prentiss</u>	
DATE		ADDRESS (Street, city, town, state)	
<u>10/30/56</u>		<u>Salisbury Ind.</u>	
REGISTRAR'S SIGNATURE		LOCATION (City, town, or county)	
<u>Mary W. Halloughy</u>		<u>Chance Ind.</u>	

BUREAU V.

1956 I NOV

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10786

10809

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powellville</u> c. LENGTH OF STAY IN lb <u>months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>616 Smith St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sally</u> Middle <u>Truitt</u> Last <u>Davis</u>			4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1956</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>William G. Truitt</u>			14. MOTHER'S MAIDEN NAME <u>Martha Niblett</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Elizabeth Calloway</u> Address <u>Salisbury, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>Earl L. Royer</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>			DATE SIGNED <u>10-20-56</u>				
22a. BURIAL, CREMATION, REMAINS (Specify) <u>Oct. 21, 1956</u>		22b. DATE THEREOF <u>Truitt</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Willards, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Selbyville</u>			24a. REC'D BY REGISTRAR <u>24 1956</u>				
24b. REGISTRAR'S SIGNATURE <u>Mary H. Calloway</u>			24c. REGISTRAR'S SIGNATURE <u>Mary H. Calloway</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10787

10780

CERTIFICATE OF DEATH

Dr. Carrie Hearn M.D.-Salisbury, Md.

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		STREET ADDRESS (If rural give location) Snow Hill Road	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY (Middle) JOHNNA (Last) DE FORGE				(Month) OCT. (Day) 8th (Year) 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH September 28, 1908	9. AGE last birthday 48 yrs.	IF UNDER 1 YEAR Months 0 Days 10		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter Brewer				14. MOTHER'S MAIDEN NAME Lillian Loving			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Warren L. DeForge (Husband) Snow Hill Road - Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 531.2 Brain Abscess						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Disseminated teeth (8 removed 2 weeks previously)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 10/3/56		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/3/56, 19 to 10/8/56, 19, that I last saw the deceased alive on 10/8/56, 19, and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
SIGNATURE <i>Dr. Carrie Hearn</i>		DATE THEREOF Oct. 11, 1956		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR Oct 19 1956		25. FUNERAL DIRECTOR'S SIGNATURE <i>Holloway & Company</i>		ADDRESS HOLLOWAY & COMPANY - SALISBURY, MARYLAND	

Dr. David A. Green, D.D., President

DOI: 10.1002/for

09-17-1968

BUREAU V. S.

9 OCT 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10788

10781

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>		23-42-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>434 Banks Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>DOUGLAS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 31 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u>	8. DATE OF BIRTH <u>October 30, 1956</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	<u>21 40</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Doris Lucille Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
762.5 IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Intraventricular Hemorrhage</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Atelectasia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prematurity</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/30</u> , 19 <u>56</u> , to <u>10/31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>56</u> , and that death occurred at <u>8:00 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>11/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>11/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital, Salisbury, Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Zelloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11-6-56</u>							

208222.1XV1

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 1, 1900*

5. PLACE OF BIRTH: *Baltimore, Md.*

6. OCCUPATION: *Teacher*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *Nov 1, 1945*

9. PLACE OF DEATH: *Home*

10. SIGNATURE OF PHYSICIAN: *Dr. J. H. Smith*

11. SIGNATURE OF REGISTRAR: *John Doe*

12. SIGNATURE OF WITNESS: *John Doe*

13. SIGNATURE OF WITNESS: *John Doe*

14. SIGNATURE OF WITNESS: *John Doe*

15. SIGNATURE OF WITNESS: *John Doe*

16. SIGNATURE OF WITNESS: *John Doe*

17. SIGNATURE OF WITNESS: *John Doe*

18. SIGNATURE OF WITNESS: *John Doe*

19. SIGNATURE OF WITNESS: *John Doe*

20. SIGNATURE OF WITNESS: *John Doe*

21. SIGNATURE OF WITNESS: *John Doe*

22. SIGNATURE OF WITNESS: *John Doe*

23. SIGNATURE OF WITNESS: *John Doe*

24. SIGNATURE OF WITNESS: *John Doe*

25. SIGNATURE OF WITNESS: *John Doe*

26. SIGNATURE OF WITNESS: *John Doe*

27. SIGNATURE OF WITNESS: *John Doe*

28. SIGNATURE OF WITNESS: *John Doe*

BUREAU V. S.

NOV 7 1945

RECEIVED

2011-11-17 14:11:11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10789

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 11, 10a, 13, 14 File G206 11-7-56 et

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Gillette</u> Last <u>Gillette</u>				4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>19 56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>G</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Achen, South Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of the brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardio-vascular disease</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>10-27-56</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>County Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. ...</u>				ADDRESS <u>Snow Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>Mary K. ...</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary K. ...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF SURVIVORS		SIGNATURE OF OTHERS	

RECEIVED
 NOV 1 1956
 BUREAU V. 1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10790

10783 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place) <u>1 Day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>512 Wicomico</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>GORDY</u>				<u>OCTOBER 12 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCTOBER 11 1956</u>	9. AGE last birthday yrs. <u>12</u>	IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Frederique Layman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Mary Layman</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
760.5 IMMEDIATE CAUSE (A) <u>Intraventricular Cerebral Hemorrhage</u>						<u>7 & 8 hours</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Prematurity</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11 Oct 1956</u> , to <u>12 Oct 1956</u> , that I last saw the deceased alive on <u>12 Oct 1956</u> , and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>R. Sanders</u>		M.D. <u>926 N. Division St Salisbury</u>		ADDRESS (Street, city, town, state) <u>1800 1st</u>		DATE SIGNED <u>18 Oct 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>10-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>PENINSULA GENERAL Hospital Salisbury, Wicomico, Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE <u>10-18-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md</u>		ADDRESS	

2082192XV2

CERTIFICATE OF DEATH

Date of Death

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Cause of Death

8. Date of Burial

9. Place of Burial

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Minister

14. Signature of Undertaker

15. Signature of Family

16. Signature of Friends

17. Signature of Neighbors

18. Signature of Community

19. Signature of Church

20. Signature of School

21. Signature of Employer

22. Signature of Neighbor

23. Signature of Friend

24. Signature of Relative

25. Signature of Other

26. Signature of Minister

27. Signature of Undertaker

28. Signature of Family

29. Signature of Friends

30. Signature of Neighbors

31. Signature of Community

32. Signature of Church

33. Signature of School

34. Signature of Employer

35. Signature of Neighbor

36. Signature of Friend

37. Signature of Relative

38. Signature of Other

39. Signature of Minister

40. Signature of Undertaker

41. Signature of Family

42. Signature of Friends

43. Signature of Neighbors

44. Signature of Community

45. Signature of Church

46. Signature of School

47. Signature of Employer

48. Signature of Neighbor

49. Signature of Friend

50. Signature of Relative

51. Signature of Other

52. Signature of Minister

53. Signature of Undertaker

54. Signature of Family

55. Signature of Friends

56. Signature of Neighbors

57. Signature of Community

58. Signature of Church

59. Signature of School

60. Signature of Employer

61. Signature of Neighbor

62. Signature of Friend

63. Signature of Relative

64. Signature of Other

65. Signature of Minister

66. Signature of Undertaker

67. Signature of Family

68. Signature of Friends

69. Signature of Neighbors

70. Signature of Community

71. Signature of Church

72. Signature of School

73. Signature of Employer

74. Signature of Neighbor

75. Signature of Friend

76. Signature of Relative

77. Signature of Other

78. Signature of Minister

79. Signature of Undertaker

80. Signature of Family

81. Signature of Friends

82. Signature of Neighbors

83. Signature of Community

84. Signature of Church

85. Signature of School

86. Signature of Employer

87. Signature of Neighbor

88. Signature of Friend

89. Signature of Relative

90. Signature of Other

91. Signature of Minister

92. Signature of Undertaker

93. Signature of Family

94. Signature of Friends

95. Signature of Neighbors

96. Signature of Community

97. Signature of Church

98. Signature of School

99. Signature of Employer

100. Signature of Neighbor

101. Signature of Friend

102. Signature of Relative

103. Signature of Other

104. Signature of Minister

105. Signature of Undertaker

106. Signature of Family

107. Signature of Friends

108. Signature of Neighbors

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112. Signature of Employer

113. Signature of Neighbor

114. Signature of Friend

115. Signature of Relative

116. Signature of Other

117. Signature of Minister

118. Signature of Undertaker

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121. Signature of Neighbors

122. Signature of Community

123. Signature of Church

124. Signature of School

125. Signature of Employer

126. Signature of Neighbor

127. Signature of Friend

128. Signature of Relative

129. Signature of Other

130. Signature of Minister

131. Signature of Undertaker

132. Signature of Family

133. Signature of Friends

134. Signature of Neighbors

135. Signature of Community

136. Signature of Church

137. Signature of School

138. Signature of Employer

139. Signature of Neighbor

140. Signature of Friend

141. Signature of Relative

142. Signature of Other

143. Signature of Minister

144. Signature of Undertaker

145. Signature of Family

146. Signature of Friends

147. Signature of Neighbors

148. Signature of Community

149. Signature of Church

150. Signature of School

151. Signature of Employer

152. Signature of Neighbor

153. Signature of Friend

154. Signature of Relative

155. Signature of Other

156. Signature of Minister

157. Signature of Undertaker

158. Signature of Family

159. Signature of Friends

160. Signature of Neighbors

161. Signature of Community

162. Signature of Church

163. Signature of School

164. Signature of Employer

165. Signature of Neighbor

166. Signature of Friend

167. Signature of Relative

168. Signature of Other

169. Signature of Minister

170. Signature of Undertaker

171. Signature of Family

172. Signature of Friends

173. Signature of Neighbors

174. Signature of Community

175. Signature of Church

176. Signature of School

177. Signature of Employer

178. Signature of Neighbor

179. Signature of Friend

180. Signature of Relative

181. Signature of Other

182. Signature of Minister

183. Signature of Undertaker

184. Signature of Family

185. Signature of Friends

186. Signature of Neighbors

187. Signature of Community

188. Signature of Church

189. Signature of School

190. Signature of Employer

191. Signature of Neighbor

192. Signature of Friend

193. Signature of Relative

194. Signature of Other

195. Signature of Minister

196. Signature of Undertaker

197. Signature of Family

198. Signature of Friends

199. Signature of Neighbors

200. Signature of Community

201. Signature of Church

202. Signature of School

203. Signature of Employer

204. Signature of Neighbor

205. Signature of Friend

206. Signature of Relative

207. Signature of Other

208. Signature of Minister

209. Signature of Undertaker

210. Signature of Family

211. Signature of Friends

212. Signature of Neighbors

213. Signature of Community

214. Signature of Church

215. Signature of School

216. Signature of Employer

217. Signature of Neighbor

218. Signature of Friend

219. Signature of Relative

220. Signature of Other

221. Signature of Minister

222. Signature of Undertaker

223. Signature of Family

224. Signature of Friends

225. Signature of Neighbors

226. Signature of Community

227. Signature of Church

228. Signature of School

229. Signature of Employer

230. Signature of Neighbor

231. Signature of Friend

232. Signature of Relative

233. Signature of Other

234. Signature of Minister

235. Signature of Undertaker

236. Signature of Family

237. Signature of Friends

238. Signature of Neighbors

239. Signature of Community

240. Signature of Church

241. Signature of School

242. Signature of Employer

243. Signature of Neighbor

244. Signature of Friend

245. Signature of Relative

246. Signature of Other

247. Signature of Minister

248. Signature of Undertaker

249. Signature of Family

250. Signature of Friends

251. Signature of Neighbors

252. Signature of Community

253. Signature of Church

254. Signature of School

255. Signature of Employer

256. Signature of Neighbor

257. Signature of Friend

258. Signature of Relative

259. Signature of Other

260. Signature of Minister

261. Signature of Undertaker

262. Signature of Family

263. Signature of Friends

264. Signature of Neighbors

265. Signature of Community

266. Signature of Church

267. Signature of School

268. Signature of Employer

269. Signature of Neighbor

270. Signature of Friend

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10791

10784

CERTIFICATE OF DEATH

Reg. Dist. No. 334

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Salisbury</u>		<u>19 DAYS</u>		OR TOWN <u>Berlin</u>		<u>23x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Route 3</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>BERTHA COLLIN HAGGERTY</u>				(Month) (Day) (Year) <u>OCTOBER 28 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>		<u>OCT. 12, 1887</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>OWN HOME</u>		<u>PHILADELPHIA, PA.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>MICHEL J. COLLIN</u>				<u>BERTHA COLEMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>MISS MARGARET B. HAGGERTY</u> <u>Berlin Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pulmonary Fibrosis & emphysema</u>							
				<u>Arteriosclerotic Heart Disease</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-8-56</u> to <u>10-28-56</u> , that I last saw the deceased alive on <u>Oct 28 1956</u> , and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Wanda Saltsbury</u> M.D.				DATE SIGNED <u>Oct 28 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT. 31, 1956</u>		<u>HOLY SEPULCHRE</u>		<u>PHILADELPHIA PA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>OCT 31 1956</u>		<u>Mary H. Hallaway</u>		<u>Anna A. Burbage</u>		<u>Berlin Md</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

14 DAYS

Corlin

Oct. 19, 1961

PHILADELPHIA, PA., U.S.A.

HOUSEWIFE Own Home

Michael J. Corlin

BETNA COLEMAN

None

No

No

Miss Margaret B. Hareedy

BUREAU V. 3

OCT 31 1966

RECEIVED

OCT 31 1966 Holy Sepulchre

Anna N. Barker Berlin Md

10785

CERTIFICATE OF DEATH

Reg. Dist. No.

1079233 ✓

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle Hazelton Last		4. DATE OF DEATH Month Oct. Day 6 Year 19 56	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1885
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unk	
14. MOTHER'S MAIDEN NAME Josephine Dugger		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk	
16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilis heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH unk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CNS syphilis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 12, 1954 , to Oct. 6, 1956 , that I last saw the deceased alive on Oct. 6, 1956 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 10/7/56			
ACTUAL SIGNATURE L.V. Maldve		M.D. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) L.V. Maldve, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/11/56	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chester Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James B. Shiel		ADDRESS Easton, Md.	24b. REGISTRAR'S SIGNATURE Mary H. Williams
24a. REC'D BY REGISTRAR DATE 10-15-1956			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10810
CERTIFICATE OF DEATH

10793
331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Railroad Ave.		d. STREET ADDRESS Railroad Ave.	
3. NAME OF DECEASED (Type or print) First NAPOLEON Middle HITCH Last HITCH		4. DATE OF DEATH Month OCT. Day 5 th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1881
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill	
11. BIRTHPLACE (State or foreign country) Sussex County Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Hitch		14. MOTHER'S MAIDEN NAME Catherine (Unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Fannie A. Hitch (Wife)		Address Railroad Ave. Mardela, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1st, 1956 to October 4th, 1956 , that I last saw the deceased alive on October 4th, 1956 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Emrich M.D.		ADDRESS (Street, city or town, state) Hebron, Maryland	
DATE SIGNED October 6th 1956			
PHYSICIAN'S NAME (Type) Dr. William Emrich			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 1956	
22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		22d. LOCATION (City, town, or county) (State) Mardela Springs, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Nancy Holloway			

RECEIVED
OCT 9 1956
BUREAU V. 3

BUREAU V. 3

1956 9 OCT

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10794

10786

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>4 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>		<u>23-42-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General</u>				STREET ADDRESS (If rural give location) <u>P.O. Box 53</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Elton</u>		(Middle)		(Last) <u>Hope</u>		(Month) (Day) (Year) <u>10-24-1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>JULY 25-1906</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAWYER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER MILL</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WILLIAM H HOPE</u>				14. MOTHER'S MAIDEN NAME <u>ETA V. TULL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>189-09-5659</u>		17. INFORMANT & ADDRESS <u>Mrs GRACE C. HOPE</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>William E. Elders Jr.</u>				DATE SIGNED <u>Salisbury, Md. 10-25-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>	
24. REC'D BY REGISTRAR <u>Oct 25 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Gallaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry R. Watson</u>		ADDRESS <u>Pocomoke Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

Maryland

2. SEX

Female

3. AGE

45 years

4. PLACE OF BIRTH

Rockford, Ill.

5. OCCUPATION

Editor

6. CAUSE OF DEATH

Heart

7. COLOR

White

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

BUREAU V. S. X.

OCT 29 1956

RECEIVED

10-24-56
J. Edgar Hoover

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10795

10787

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 304 Poplar Hill Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle PALMER Last HOPKINS		4. DATE OF DEATH Month OCTOBER Day 24th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Poultryman		10b. KIND OF BUSINESS OR INDUSTRY Chickening Work	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Alexander Hopkins		14. MOTHER'S MAIDEN NAME Ida (Unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lydia L. Hopkins (Wife)		Address 304 Poplar Hill Ave/ Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomp 525x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Fibrosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-4 wks yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19, 1956 , to Oct 24, 1956 , that I last saw the deceased alive on Oct 24, 1956 , and that death occurred at 9:50 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 334 Camden Ave. Salisbury, Maryland	
DATE SIGNED Oct. 25 1956			
ACTUAL SIGNATURE William D. Gray M.D.			
PHYSICIAN'S NAME (Type) Dr. William D. Gray M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 27, 1956	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS 334 Camden Ave. Salisbury, Maryland	
24a. REC'D BY REGISTRAR 29 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

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BUREAU 4

OCT 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10811
CERTIFICATE OF DEATH

10796
Reg. Dist. No. 33✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Horner</u> Last <u>Horner</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-1886</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James E. Horner</u>		14. MOTHER'S MAIDEN NAME <u>Luvacey Jane Hurley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT Address <u>Mrs. Reese Horner, Tyaskin, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/4/49</u> , 19 <u>56</u> , to <u>10/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/7</u> , 19 <u>56</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.		DATE SIGNED <u>10/10/56</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>		<u>Nanticoke, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. W. [Signature]</u>		ADDRESS <u>Bivalve, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Oct 18 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

1956 18 OCT

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10788

CERTIFICATE OF DEATH

Item 11, See: Birth Cert.

10797

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FRUITLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 256</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Jones</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 20 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10-18-56</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days <u>2</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>ELAINE MATILDA WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
771.5 IMMEDIATE CAUSE (A) <u>Interventricular Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hemorrhage disease of the Newborn</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Prematurity</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Meconium Ileus</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/18</u> <u>1956</u> , to <u>10/20</u> <u>1956</u> , that I last saw the deceased alive on <u>10/20</u> <u>1956</u> , and that death occurred at <u>10:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>10/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>PENINSULA GENERAL HOSPITAL, Salisbury, Wicomico, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary W. Holloway</u>		ADDRESS	
DATE <u>10/24/56</u>							

2082317XV2

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male* 3. AGE: *45* 4. OCCUPATION: *Teacher*

5. DATE OF DEATH: *Oct 25 1956* 6. PLACE OF DEATH: *Home*

7. CAUSE OF DEATH: *Heart Disease*

8. MEDICAL CERTIFICATION: *Physician*

9. SIGNATURE OF DECEASED: *John Doe*

10. SIGNATURE OF WITNESSES: *John Doe*

11. SIGNATURE OF DECEASED: *John Doe*

12. SIGNATURE OF DECEASED: *John Doe*

13. SIGNATURE OF DECEASED: *John Doe*

RECEIVED
OCT 29 1956
BUREAU V. 2

NOTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

10812
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

10798
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldy</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldy</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Martenia</u> First <u>Jr</u> Middle <u>Jr</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1886</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Calverton Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-16-8195</u>		17. INFORMANT <u>Thomas Jones</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 Sept. 1956</u> to <u>31 Oct. 1956</u> that I last saw the deceased alive on <u>31 Oct. 1956</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke Md</u>		DATE SIGNED <u>11/2/56</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS</u>				<u>NANTICOKE Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>Waldy Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boaker H. Huest</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>11-8-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		for S.D.P.	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF DEATH <i>Dec 10 1956</i>		10. PLACE OF DEATH <i>Home</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. NAME OF DECEASED <i>John Doe</i>		22. SEX <i>Male</i>		23. AGE <i>45</i>		24. DATE OF BIRTH <i>Jan 15 1910</i>		25. PLACE OF BIRTH <i>Baltimore, Md.</i>		26. RACE <i>White</i>		27. OCCUPATION <i>Teacher</i>		28. MARITAL STATUS <i>Married</i>		29. DATE OF DEATH <i>Dec 10 1956</i>		30. PLACE OF DEATH <i>Home</i>		31. CAUSE OF DEATH <i>Heart Disease</i>		32. MANNER OF DEATH <i>Natural</i>		33. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		34. SIGNATURE OF REGISTRAR <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	

50

BUREAU V. S.

NOV 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10813
 CERTIFICATE OF DEATH

10800
 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Parsonage St				d. STREET ADDRESS Parsonage St			
3. NAME OF DECEASED (Type or print) First NELLIE Middle LEE Last LIVELY				4. DATE OF DEATH Month OCTOBER Day 12th Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1906		9. AGE (In years last birthday) yrs. 50	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at own Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Mt. Vernon, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Ira T. Banks				14. MOTHER'S MAIDEN NAME Flora Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Burton B. Lively (Husband)				Address Parsonage St. Fruitland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 15 MIN
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from OCT 30 , 19 53 , to OCT 12 , 19 56 , that I last saw the deceased alive on OCT 12 , 19 56 , and that death occurred at 7:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley				ADDRESS (Street, city or town, state) 116 E. Main St (Office) Oct. 15 1956			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley M.D.				DATE SIGNED Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR OCT 18 1956		24b. REGISTRAR'S SIGNATURE Mary H. Hanger	

CERTIFICATE OF DEATH

1. NAME OF DECEASED J. J. J. J.		2. SEX M		3. AGE 45		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH BALTIMORE, MD.	
6. OCCUPATION Clerk		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. DECEASED AT Home		12. PLACE OF DEATH Home		13. DATE OF DEATH 1956		14. TIME OF DEATH 10:00 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Heart Disease		17. PERIOD OF ILLNESS 2 weeks		18. PRESENT ILLNESS Angina		19. PREVIOUS ILLNESS Hypertension		20. MEDICAL HISTORY None	
21. NAME OF PHYSICIAN Dr. J. J. J.		22. NAME OF HOSPITAL None		23. NAME OF NURSE None		24. NAME OF ASSISTANT None		25. NAME OF ATTENDING None	
26. NAME OF FUNERAL HOME None		27. NAME OF BURIAL PLACE None		28. NAME OF CEMETERY None		29. NAME OF INTERMENT None		30. NAME OF CREMATION None	
31. NAME OF NEXT OF KIN None		32. NAME OF SURVIVOR None		33. NAME OF SURVIVOR None		34. NAME OF SURVIVOR None		35. NAME OF SURVIVOR None	
36. NAME OF SURVIVOR None		37. NAME OF SURVIVOR None		38. NAME OF SURVIVOR None		39. NAME OF SURVIVOR None		40. NAME OF SURVIVOR None	
41. NAME OF SURVIVOR None		42. NAME OF SURVIVOR None		43. NAME OF SURVIVOR None		44. NAME OF SURVIVOR None		45. NAME OF SURVIVOR None	
46. NAME OF SURVIVOR None		47. NAME OF SURVIVOR None		48. NAME OF SURVIVOR None		49. NAME OF SURVIVOR None		50. NAME OF SURVIVOR None	
51. NAME OF SURVIVOR None		52. NAME OF SURVIVOR None		53. NAME OF SURVIVOR None		54. NAME OF SURVIVOR None		55. NAME OF SURVIVOR None	
56. NAME OF SURVIVOR None		57. NAME OF SURVIVOR None		58. NAME OF SURVIVOR None		59. NAME OF SURVIVOR None		60. NAME OF SURVIVOR None	
61. NAME OF SURVIVOR None		62. NAME OF SURVIVOR None		63. NAME OF SURVIVOR None		64. NAME OF SURVIVOR None		65. NAME OF SURVIVOR None	
66. NAME OF SURVIVOR None		67. NAME OF SURVIVOR None		68. NAME OF SURVIVOR None		69. NAME OF SURVIVOR None		70. NAME OF SURVIVOR None	
71. NAME OF SURVIVOR None		72. NAME OF SURVIVOR None		73. NAME OF SURVIVOR None		74. NAME OF SURVIVOR None		75. NAME OF SURVIVOR None	
76. NAME OF SURVIVOR None		77. NAME OF SURVIVOR None		78. NAME OF SURVIVOR None		79. NAME OF SURVIVOR None		80. NAME OF SURVIVOR None	
81. NAME OF SURVIVOR None		82. NAME OF SURVIVOR None		83. NAME OF SURVIVOR None		84. NAME OF SURVIVOR None		85. NAME OF SURVIVOR None	
86. NAME OF SURVIVOR None		87. NAME OF SURVIVOR None		88. NAME OF SURVIVOR None		89. NAME OF SURVIVOR None		90. NAME OF SURVIVOR None	
91. NAME OF SURVIVOR None		92. NAME OF SURVIVOR None		93. NAME OF SURVIVOR None		94. NAME OF SURVIVOR None		95. NAME OF SURVIVOR None	
96. NAME OF SURVIVOR None		97. NAME OF SURVIVOR None		98. NAME OF SURVIVOR None		99. NAME OF SURVIVOR None		100. NAME OF SURVIVOR None	

RECEIVED
OCT 18 1956
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10789
CERTIFICATE OF DEATH

10802

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dalestony</i> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dalestony</i> d. STREET ADDRESS <i>415 Booth St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Emma</i> First <i>V. Nichols</i> Middle <i>L.</i> Last 4. DATE OF DEATH <i>Oct 4</i> Month <i>19</i> Day <i>1956</i> Year		5. SEX <i>F</i> 6. COLOR OR RACE <i>E</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>70</i> yrs. 9. AGE (In years last birthday) <i>70</i> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Snuff</i> 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John W. Sundry</i> 14. MOTHER'S MAIDEN NAME <i>Mary E. Barker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <i>214-32-377</i> 17. INFORMANT <i>Ida Walter</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary atherosclerotic heart disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>8 months</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3 Feb</i> , 19 <i>55</i> , to <i>4 Oct</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12 Feb</i> , 19 <i>56</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>152 W. Main St., Salisbury, Md.</i> DATE SIGNED <i>7 Nov 1956</i>			
ACTUAL SIGNATURE <i>E. A. Purvell</i> M.D. PHYSICIAN'S NAME (Type) <i>E. A. PURVELL, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>Oct 7, 1956</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Green Grove</i> 22d. LOCATION (City, town, or county) <i>Dalestony</i> (State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker M. Welch</i> ADDRESS 24a. REC'D BY REGISTRAR <i>10-9-56</i> 24b. REGISTRAR'S SIGNATURE <i>Madeline Holloway</i>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF CHURCH OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>21. SIGNATURE OF BURIAL OFFICIAL</p>		<p>22. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>23. SIGNATURE OF BURIAL OFFICIAL</p>		<p>24. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>25. SIGNATURE OF BURIAL OFFICIAL</p>		<p>26. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>27. SIGNATURE OF BURIAL OFFICIAL</p>		<p>28. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>29. SIGNATURE OF BURIAL OFFICIAL</p>		<p>30. SIGNATURE OF INTERMENT OFFICIAL</p>	
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<p>99. SIGNATURE OF BURIAL OFFICIAL</p>		<p>100. SIGNATURE OF INTERMENT OFFICIAL</p>	

BUREAU V. 3

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10790

CERTIFICATE OF DEATH

10803

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS X			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Robert Grant Nutter		First Middle Last		4. DATE OF DEATH October 23 1956		Month Day Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1956	9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Grant Waters				14. MOTHER'S MAIDEN NAME Constance Nutter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		17. INFORMANT Grant Waters, Nanticoke, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Bronchiolitis DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH 3 hrs 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Heart Disease & Patent Ductus & Foramen Ovale				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 10/22, 1956 , to 10/23, 1956 , that I last saw the deceased alive on 10/22, 1956 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William C. Morgan M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/56		22c. NAME OF CEMETERY OR CREMATORY Nanticoke Cem.		22d. LOCATION (City, town, or county) (State) Nanticoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Hesse		ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR 06 29 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

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OCT 29 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10791

CERTIFICATE OF DEATH

10804

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury				c. LENGTH OF STAY IN 1b 52 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clayton Middle A. Last Parker				4. DATE OF DEATH Month October Day 5 Year 19 56			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Parker				14. MOTHER'S MAIDEN NAME Mary Parsons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Azotemia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Glomerulonephritis, chronic DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 months ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 13 , 19 56 , to Oct. 5 , 19 56 , that I last saw the deceased alive on Oct. 4 , 19 56 , and that death occurred at 4:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 10/5/56							
ACTUAL SIGNATURE V. Juerman M.D.				DEER'S HEAD STATE HOSPITAL			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Glenn Hill Cem		22d. LOCATION (City, town, or county) (State) Parsonsburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Booker W. Cress ADDRESS				24a. REC'D BY REGISTRAR DATE 10-10-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloman	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G206 11-2-56 et

10792

CERTIFICATE OF DEATH

10805

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 5 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 425 West College Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eliza Middle Polliard Last Polliard				4. DATE OF DEATH Month 10 Day 20 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1865	9. AGE (In years last birthday) yrs. 91 89	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Patterson				14. MOTHER'S MAIDEN NAME Mary Maise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. R.H. Polliard, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Spont. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE W. B. Smith M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED 10/22-56	
PHYSICIAN'S NAME (Type) Dr. William B. Smith, Medical Center, Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/56		22c. NAME OF CEMETERY OR CREMATORY Manokin Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE 10-24-56		24b. REGISTRAR'S SIGNATURE Mary W. Halloway	

Thomas T. Baker

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928	
5. PLACE OF BIRTH Jackson, Tennessee		6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White	
9. PRESENT ADDRESS Room 10, 1000 North Broadway, Baltimore, Md.		10. DATE OF DEATH May 2, 1968		11. PLACE OF DEATH Room 10, 1000 North Broadway, Baltimore, Md.		12. CAUSE OF DEATH Suicide by gunshot	
13. MANNER OF DEATH Suicide		14. MEDICAL HISTORY None		15. PREVIOUS ILLNESS None		16. PREVIOUS SURGERY None	
17. SIGNATURE OF DECEASED James Earl Ray		18. SIGNATURE OF WITNESS James Earl Ray		19. SIGNATURE OF PHYSICIAN James Earl Ray		20. SIGNATURE OF CORONER James Earl Ray	
21. SIGNATURE OF REGISTRAR James Earl Ray		22. SIGNATURE OF CLERK James Earl Ray		23. SIGNATURE OF NURSE James Earl Ray		24. SIGNATURE OF CHAPLAIN James Earl Ray	
25. SIGNATURE OF MINISTER James Earl Ray		26. SIGNATURE OF RABBI James Earl Ray		27. SIGNATURE OF PRIEST James Earl Ray		28. SIGNATURE OF OTHER James Earl Ray	
29. SIGNATURE OF DECEASED James Earl Ray		30. SIGNATURE OF WITNESS James Earl Ray		31. SIGNATURE OF PHYSICIAN James Earl Ray		32. SIGNATURE OF CORONER James Earl Ray	
33. SIGNATURE OF REGISTRAR James Earl Ray		34. SIGNATURE OF CLERK James Earl Ray		35. SIGNATURE OF NURSE James Earl Ray		36. SIGNATURE OF CHAPLAIN James Earl Ray	
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61. SIGNATURE OF MINISTER James Earl Ray		62. SIGNATURE OF RABBI James Earl Ray		63. SIGNATURE OF PRIEST James Earl Ray		64. SIGNATURE OF OTHER James Earl Ray	
65. SIGNATURE OF DECEASED James Earl Ray		66. SIGNATURE OF WITNESS James Earl Ray		67. SIGNATURE OF PHYSICIAN James Earl Ray		68. SIGNATURE OF CORONER James Earl Ray	
69. SIGNATURE OF REGISTRAR James Earl Ray		70. SIGNATURE OF CLERK James Earl Ray		71. SIGNATURE OF NURSE James Earl Ray		72. SIGNATURE OF CHAPLAIN James Earl Ray	
73. SIGNATURE OF MINISTER James Earl Ray		74. SIGNATURE OF RABBI James Earl Ray		75. SIGNATURE OF PRIEST James Earl Ray		76. SIGNATURE OF OTHER James Earl Ray	
77. SIGNATURE OF DECEASED James Earl Ray		78. SIGNATURE OF WITNESS James Earl Ray		79. SIGNATURE OF PHYSICIAN James Earl Ray		80. SIGNATURE OF CORONER James Earl Ray	
81. SIGNATURE OF REGISTRAR James Earl Ray		82. SIGNATURE OF CLERK James Earl Ray		83. SIGNATURE OF NURSE James Earl Ray		84. SIGNATURE OF CHAPLAIN James Earl Ray	
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89. SIGNATURE OF DECEASED James Earl Ray		90. SIGNATURE OF WITNESS James Earl Ray		91. SIGNATURE OF PHYSICIAN James Earl Ray		92. SIGNATURE OF CORONER James Earl Ray	
93. SIGNATURE OF REGISTRAR James Earl Ray		94. SIGNATURE OF CLERK James Earl Ray		95. SIGNATURE OF NURSE James Earl Ray		96. SIGNATURE OF CHAPLAIN James Earl Ray	
97. SIGNATURE OF MINISTER James Earl Ray		98. SIGNATURE OF RABBI James Earl Ray		99. SIGNATURE OF PRIEST James Earl Ray		100. SIGNATURE OF OTHER James Earl Ray	

BUREAU V. 1

OCT 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10793 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10806

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>4 hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha</u> <u>Price</u>				4. DATE OF DEATH Month Day Year <u>10</u> <u>9</u> <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>O</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 10 - 1911</u>		9. AGE (In years last birthday) <u>45 1/2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>Andrew Timmes</u>				14. MOTHER'S MAIDEN NAME <u>Leiah Bellins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-16-7181</u>		17. INFORMANT Address <u>Viola Price Stearns, 1069 Myrtle Ave Baltimore, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral circulatory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple compound fractures</u> DUE TO (c) 816x							INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>4 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving car involved in a two car collision.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>10-9-19 56</u> <u>2:45 P.M.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Newark Worcester Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				DATE SIGNED <u>10-9-56</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Timmes, Snow Hill, Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 15 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Holloway</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10814

CERTIFICATE OF DEATH

10807

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mardela Springs		LENGTH OF STAY (in this place) 70 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mardela Springs			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main Street				STREET ADDRESS (If rural give location) Main Street			
3. NAME OF DECEASED (Type or Print) Edward W. Russell				4. DATE OF DEATH (Month) (Day) (Year) Oct. 16 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Widowed	8. DATE OF BIRTH Oct. 11, 1877	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Wicomico County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Algeon Russell				14. MOTHER'S MAIDEN NAME Arcadia Gravenor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Frank Russell, Easton, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
592x IMMEDIATE CAUSE (A) Pulmonary Edema (acute)						2 weeks	
ANTECEDENT CAUSE(S) DUE TO Chronic Myocarditis						6 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Chronic Nephritis						7 years	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Aug. 31, 1956 to Oct. 6, 1956 , that I last saw the deceased alive on Oct. 13, 1956 , and that death occurred at 10:55 A.M. from the causes and on the date stated above.							
SIGNATURE M. Spitznagel				ADDRESS (Street, city, town, state) Mardela Springs, Md.			
DATE OCT 19 1956				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-18-56		NAME OF CEMETERY OR CREMATOR Mardela		LOCATION (City, town, or county) (State) Mardela Springs, Md.	
24. REC'D BY REGISTRAR Mary H. Holloway		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Charles W. Marshall, Shapton, Md.		ADDRESS	

CERTIFICATE OF DEATH

Rev. Date: 10-19-56

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and Months)

4. Date of death (Month, Day, Year)

5. Place of death (City, State, Country)

6. Cause of death (Print or write full name)

7. Date of death (Month, Day, Year)

8. Signature of physician (Print or write full name)

9. Signature of registrar (Print or write full name)

10. Date of death (Month, Day, Year)

11. Signature of physician (Print or write full name)

12. Signature of registrar (Print or write full name)

13. Signature of physician (Print or write full name)

BUREAU V. 3

OCT 19 1956

RECEIVED

ENCLOSURE

ATTACHED TO MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9,13,14,16 Film G206 11-5-56 et

10794

CERTIFICATE OF DEATH

10808

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 431 Somerset Ave.			
3. NAME OF DECEASED (Type or print) THOMAS First Middle Last SHILL				4. DATE OF DEATH Month 10 Day 21 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx. 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturant Owner		10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Shill				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W. II		16. SOCIAL SECURITY NO. 211-32-6784		17. INFORMANT Mrs. Thomas Shill		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 9-1 , 19 56 , to 10-21 , 19 56 , that I last saw the deceased alive on 10-21 , 19 56 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. O. Ellis, Jr.				ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 10-22-56			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/24/1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George C. 7th St				ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE 10-24-56	
						24b. REGISTRAR'S SIGNATURE Mary W Holloway	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		123 Main St		Heart Disease		Jan 15, 1956		10:00 AM		City of Baltimore		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Education		Religion		Race		Color		Sex of Deceased		Sex of Registrar		Signature of Deceased		Signature of Registrar		Signature of Physician		Signature of Registrar	
Teacher		Married		High School		Catholic		White		White		Male		Male		John Doe		John Doe		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Cause of Death	
Jan 15, 1956		10:00 AM		City of Baltimore		Heart Disease		Jan 15, 1956		10:00 AM		City of Baltimore		Heart Disease		Jan 15, 1956		10:00 AM		City of Baltimore		Heart Disease	
Signature of Deceased		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Registrar		Signature of Physician		Signature of Registrar	
John Doe		John Doe		J. Doe, M.D.		J. Doe, M.D.		John Doe		John Doe		J. Doe, M.D.		J. Doe, M.D.		John Doe		John Doe		J. Doe, M.D.		J. Doe, M.D.	

BUREAU V. S.

OCT 29 1956

RECEIVED

10815

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

335

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Smiley</u> Last <u>Smiley</u>				4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Esther Juntor</u> Address <u>Sharptown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic cardio-vascular disease</u> (c) <u> </u> DUE TO (a) <u>422.1</u> (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> years <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF <u>10/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharptown, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Daniel, Barton, Md.</u>				24a. REC'D BY REGISTRAR <u>15 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary C. Conway</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CT 15 153

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10795

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10810

Reg. Dist. No.

238

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>37 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Martens</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Otis</u> Middle <u>EDWARD</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>10-</u> Day <u>29-</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 15, 1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSERY EMPLOYED NURSERY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WILLARD MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERNEST SMITH</u>				14. MOTHER'S MAIDEN NAME <u>ROSIE MORRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MR. ROLAND SMITH BERLIN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third degree burns of 95% body surface</u> <u>9/6.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause lost. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>37 hours</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned when kitchen caught fire.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> a.m. <u>10-28-56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>St. Martens Worcester Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-29-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		22d. LOCATION (City, town, or county) (State) <u>New Hope MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Buckner</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR (Date) <u>OCT 31 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollingsworth</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to 1/2 Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Mr. Roland Smith		M		42		Sept 12 1964	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City, N.Y.		New York City, N.Y.		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Alcohol Consumption	
Nursery Teacher		High School		Hypertension		Occasional	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

OCT 31 1966

RECEIVED

10/31/66 New York M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10811

10796

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Cecumio</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freutland</u> c. LENGTH OF STAY IN 1b <u>Freutland</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gen. Serv. Hosp. Pine St.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecumio</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freutland</u> d. STREET ADDRESS <u>Pine St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>M.</u> Last <u>Stanford</u>		4. DATE OF DEATH Oct <u>25</u> Month <u>1956</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5, 1901</u> 9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Freutland md</u>
13. FATHER'S NAME <u>Burn Stanford</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. <u>220-10-8281</u>	17. INFORMANT <u>Marian Stanford</u> Address <u>Freutland md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Pulmonary edema</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2-4 hrs.</u> <u>sev. year?</u> <u>year?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/16</u> , 19 <u>56</u> , to <u>10/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>56</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Mally</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 28-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Berens Camp</u>	22d. LOCATION (City, town, or county) (State) <u>Freutland md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booke</u> ADDRESS <u>McLush, Salis. md</u>		24a. REC'D BY REGISTRAR <u>DATE 10/30/56</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 0205 10-29-56 et

10797

CERTIFICATE OF DEATH

10812
337

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 mo. 7 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 4308 Shamrock Avenue	
3. NAME OF DECEASED (Type or print) First Marie Middle - Last Starkman		4. DATE OF DEATH Month Oct. Day 22 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1864
9. AGE (In years last birthday) 92		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Pfeiffer		14. MOTHER'S MAIDEN NAME Marie Pfeiffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk. ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records		Address Md. Deer's Head Hos., Salisbury	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Acute myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 14, 1956 , to Oct. 22, 1956 , that I last saw the deceased alive on Oct. 22, 1956 , and that death occurred at 4:10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		DATE SIGNED 10/22/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-56	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Cook		ADDRESS 1217 St. Paul St	
24a. REC'D BY REGISTRAR DATE Oct. 23 1956		24b. REGISTRAR'S SIGNATURE Mary H. Hallaway	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		OCT 24 1956		MEMPHIS, TENN	
RESIDENCE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MEMPHIS, TENN		OCT 19 1921		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT		CORONER	
MEMBER OF CONGRESS		HEART DISEASE		NATURAL		CORONARY THROMBOSIS		DR. J. H. HARRIS		DR. J. H. HARRIS	
RELATIONSHIP TO DECEASED		DATE OF INTERVIEW		PLACE OF INTERVIEW		NAME OF INTERVIEWER		SIGNATURE OF INTERVIEWER		SIGNATURE OF CORONER	
WIFE		OCT 24 1956		MEMPHIS, TENN		DR. J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
NAME OF NEXT OF KIN		ADDRESS OF NEXT OF KIN		CITY OF NEXT OF KIN		STATE OF NEXT OF KIN		COUNTRY OF NEXT OF KIN		DATE OF INTERVIEW	
JAMES EARL RAY		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF PHYSICIAN		ADDRESS OF PHYSICIAN		CITY OF PHYSICIAN		STATE OF PHYSICIAN		COUNTRY OF PHYSICIAN		DATE OF INTERVIEW	
DR. J. H. HARRIS		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF PATHOLOGIST		ADDRESS OF PATHOLOGIST		CITY OF PATHOLOGIST		STATE OF PATHOLOGIST		COUNTRY OF PATHOLOGIST		DATE OF INTERVIEW	
DR. J. H. HARRIS		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF BURIAL PLACE		ADDRESS OF BURIAL PLACE		CITY OF BURIAL PLACE		STATE OF BURIAL PLACE		COUNTRY OF BURIAL PLACE		DATE OF INTERVIEW	
MEMPHIS, TENN		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF FUNERAL HOME		ADDRESS OF FUNERAL HOME		CITY OF FUNERAL HOME		STATE OF FUNERAL HOME		COUNTRY OF FUNERAL HOME		DATE OF INTERVIEW	
MEMPHIS, TENN		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF MINISTER		ADDRESS OF MINISTER		CITY OF MINISTER		STATE OF MINISTER		COUNTRY OF MINISTER		DATE OF INTERVIEW	
MEMPHIS, TENN		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF CHURCH		ADDRESS OF CHURCH		CITY OF CHURCH		STATE OF CHURCH		COUNTRY OF CHURCH		DATE OF INTERVIEW	
MEMPHIS, TENN		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF CEMETERY		ADDRESS OF CEMETERY		CITY OF CEMETERY		STATE OF CEMETERY		COUNTRY OF CEMETERY		DATE OF INTERVIEW	
MEMPHIS, TENN		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF INTERVIEWER		ADDRESS OF INTERVIEWER		CITY OF INTERVIEWER		STATE OF INTERVIEWER		COUNTRY OF INTERVIEWER		DATE OF INTERVIEW	
DR. J. H. HARRIS		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	
NAME OF CORONER		ADDRESS OF CORONER		CITY OF CORONER		STATE OF CORONER		COUNTRY OF CORONER		DATE OF INTERVIEW	
DR. J. H. HARRIS		MEMPHIS, TENN		MEMPHIS, TENN		TENN		USA		OCT 24 1956	

BUREAU V. 8

OCT 24 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10813

10816 **CERTIFICATE OF DEATH**

Reg. Dist. No. 336

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WICOMICO</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Delmar</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>417 East St.</u>				STREET ADDRESS (If rural give location) <u>417 East St.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ANNIE M. Sturgis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 3, 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>MAY 12, 1882</u>	
9. AGE last birthday <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Josephus Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Addie J. Elliott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>HELEN BROWINGTON, Delmar Del</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Acute cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Hemorrhage</u>						<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio Sclerosis & Hypertension</u>						<u>3 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 3, 1955</u> to <u>Oct 3, 1956</u>, that I last saw the deceased alive on <u>Oct 3, 1956</u>, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A. H. Lynch</u>		DATE THEREOF <u>10/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		LOCATION (City, town, or county) (State) <u>Spanishbury Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>Harry Adams</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. DeShazo, Laurel, Del.</u>		DATE SIGNED <u>Oct 8 1956</u>	

MS A15C 1-55 10M

1916 CERTIFICATE OF DEATH

Mass. Reg. No.

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Cause of Death

7. Date of Death

8. Place of Death

9. Signature of Registrar

10. Signature of Physician

11. Signature of Coroner

12. Signature of Burial Officer

13. Signature of Interment Officer

14. Signature of Cemetery Officer

15. Signature of Undertaker

16. Signature of Funeral Home

17. Signature of Mortician

18. Signature of Embalmer

19. Signature of Crematorium

20. Signature of Burial Vault

21. Signature of Interment Vault

22. Signature of Burial Vault

23. Signature of Interment Vault

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BUREAU V. R.

OCT 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10814
337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital				d. STREET ADDRESS 418 E. Isabella St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LLOYD Middle JAMES Last SULLIVAN				4. DATE OF DEATH Month OCTOBER Day 21st Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 29, 1885		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter -Self Employed		10b. KIND OF BUSINESS OR INDUSTRY -House Painter		11. BIRTHPLACE (State or foreign country) R.D.# Delmar, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac Sullivan				14. MOTHER'S MAIDEN NAME Ellen Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lena Sullivan (Wife) Address 418 E. Isabella St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Cerebral Occlusion</i></u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, (c) _____ DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u><i>3 weeks</i></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u><i>Earl L. Royer</i></u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED October 23 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 24 1956		24b. REGISTRAR'S SIGNATURE <u><i>Mary H. Holloway</i></u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		October 10, 1956		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Status	
Heart Disease		Natural		Teacher		High School		Married		Middle Class	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 1

OCT 24 1956

RECEIVED

10-24-56

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10815

10817

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Allen</u>		LENGTH OF STAY (in this place) <u>All life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - Allen, Md.</u>				STREET ADDRESS (If rural give location) <u>Eden, Md. Rt. # 2 Box 50</u>			
3. NAME OF DECEASED (Type or Print) <u>Letha Otina Thompson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10 - 23 - 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Baby</u>	8. DATE OF BIRTH <u>6-24-56</u>	9. AGE last birthday Yrs. <u>3</u> Months <u>29</u> Days <u>29</u> Hours <u>Min.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baby</u>		11. BIRTHPLACE (State or foreign country) <u>P. G. Hospital, Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Baby</u>	
13. FATHER'S NAME <u>Levi C. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Josephine E. Leatherbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Baby</u>		16. SOCIAL SECURITY NO. <u>Baby</u>		17. INFORMANT & ADDRESS <u>Eden, Md. Rt. #2 Box 50</u> <u>Mrs. Josephine E. Thompson, Allen, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
493X IMMEDIATE CAUSE (A) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/22, 1956</u> , to <u>10-23, 1956</u> , that I last saw the deceased alive on <u>10-22, 1956</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Wm B Smith</u> M.D. <u>Med. Center Sby Md.</u> DATE SIGNED <u>10-24-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-24-56</u>		NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Allen, Wicomico Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>Funeral Home, Salisbury, Md.</u>	
DATE <u>OCT 29 1956</u>							

2182333XV4

CERTIFICATE OF DEATH

Form 10-1-55

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. RACE

5. OCCUPATION

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERK

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF COUNTY

23. SIGNATURE OF CITY

24. SIGNATURE OF TOWNSHIP

25. SIGNATURE OF PARISH

26. SIGNATURE OF VILLAGE

27. SIGNATURE OF HAMLET

28. SIGNATURE OF CENSUS TRACT

29. SIGNATURE OF BLOCK

30. SIGNATURE OF HOUSEHOLD

31. SIGNATURE OF ROOM

32. SIGNATURE OF BED

33. SIGNATURE OF CHAIR

34. SIGNATURE OF TABLE

35. SIGNATURE OF CUPBOARD

36. SIGNATURE OF DRAWER

37. SIGNATURE OF DOOR

38. SIGNATURE OF WINDOW

39. SIGNATURE OF PORCH

40. SIGNATURE OF PATIO

41. SIGNATURE OF GARDEN

42. SIGNATURE OF YARD

43. SIGNATURE OF DRIVE

44. SIGNATURE OF WALK

45. SIGNATURE OF PATH

46. SIGNATURE OF FENCE

47. SIGNATURE OF GATE

48. SIGNATURE OF WALL

49. SIGNATURE OF ROOF

50. SIGNATURE OF FLOOR

51. SIGNATURE OF CEILING

52. SIGNATURE OF BASE

53. SIGNATURE OF TOP

54. SIGNATURE OF END

55. SIGNATURE OF START

56. SIGNATURE OF MIDDLE

57. SIGNATURE OF POINT

58. SIGNATURE OF LINE

59. SIGNATURE OF AREA

60. SIGNATURE OF VOLUME

61. SIGNATURE OF MASS

62. SIGNATURE OF WEIGHT

63. SIGNATURE OF LENGTH

64. SIGNATURE OF WIDTH

65. SIGNATURE OF HEIGHT

66. SIGNATURE OF DEPTH

67. SIGNATURE OF THICKNESS

68. SIGNATURE OF DIAMETER

69. SIGNATURE OF CIRCUMFERENCE

70. SIGNATURE OF PERIMETER

71. SIGNATURE OF SURFACE

72. SIGNATURE OF VOLUME

73. SIGNATURE OF MASS

74. SIGNATURE OF WEIGHT

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95. SIGNATURE OF SURFACE

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117. SIGNATURE OF CIRCUMFERENCE

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119. SIGNATURE OF SURFACE

120. SIGNATURE OF VOLUME

121. SIGNATURE OF MASS

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132. SIGNATURE OF VOLUME

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167. SIGNATURE OF SURFACE

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185. SIGNATURE OF HEIGHT

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189. SIGNATURE OF CIRCUMFERENCE

190. SIGNATURE OF PERIMETER

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225. SIGNATURE OF CIRCUMFERENCE

226. SIGNATURE OF PERIMETER

227. SIGNATURE OF SURFACE

228. SIGNATURE OF VOLUME

229. SIGNATURE OF MASS

230. SIGNATURE OF WEIGHT

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232. SIGNATURE OF WIDTH

233. SIGNATURE OF HEIGHT

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235. SIGNATURE OF THICKNESS

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237. SIGNATURE OF CIRCUMFERENCE

238. SIGNATURE OF PERIMETER

239. SIGNATURE OF SURFACE

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241. SIGNATURE OF MASS

242. SIGNATURE OF WEIGHT

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244. SIGNATURE OF WIDTH

245. SIGNATURE OF HEIGHT

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247. SIGNATURE OF THICKNESS

248. SIGNATURE OF DIAMETER

249. SIGNATURE OF CIRCUMFERENCE

250. SIGNATURE OF PERIMETER

251. SIGNATURE OF SURFACE

252. SIGNATURE OF VOLUME

253. SIGNATURE OF MASS

254. SIGNATURE OF WEIGHT

255. SIGNATURE OF LENGTH

256. SIGNATURE OF WIDTH

257. SIGNATURE OF HEIGHT

258. SIGNATURE OF DEPTH

259. SIGNATURE OF THICKNESS

260. SIGNATURE OF DIAMETER

261. SIGNATURE OF CIRCUMFERENCE

262. SIGNATURE OF PERIMETER

263. SIGNATURE OF SURFACE

264. SIGNATURE OF VOLUME

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG205 10-29-56 et

10816

10799

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Parsons Road</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Warren</u> Last <u>Turner</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1885</u> <u>8/3/1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>	
11. BIRTHPLACE (State or foreign country) <u>Nanticoke, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Warren D. Turner</u>				14. MOTHER'S MAIDEN NAME <u>Tressa Robertson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-1690</u>		17. INFORMANT <u>Mrs. Mae Turner, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury, Md.</u>				20g. (County) <u>Wicomico</u>			
20h. (State) <u>Md.</u>				20i. (Country) <u>U.S.</u>			
21. I certify that I attended the deceased from <u>October 19, 1956</u> , to <u>October 19, 1956</u> , that I last saw the deceased alive on <u>October 19, 1956</u> , and that death occurred at <u>12:53 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u>				ADDRESS (Street, city or town, state) <u>224 N. Division St., Salisbury, Md.</u>			
M.D. <u> </u>				DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Turner's Cem.</u>		22d. LOCATION (City, town, or county) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messick, Bivalve, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>10/24/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollway</u>	

CERTIFICATE OF DEATH

10732

Reg. Date 10-1-56

NAME OF DECEASED JAMES ROBERTSON		SEX MALE		AGE 68		DATE OF BIRTH 1888		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		EDUCATION HIGH SCHOOL		OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF DEATH HOME		DATE OF DEATH OCT 26 1956		TIME OF DEATH 10:30 AM		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)																											
FATHER'S NAME JAMES ROBERTSON		MOTHER'S NAME JANE ROBERTSON		FATHER'S OCCUPATION LABORER		MOTHER'S OCCUPATION HOUSEWIFE		FATHER'S PLACE OF BIRTH BALTIMORE, MARYLAND		MOTHER'S PLACE OF BIRTH BALTIMORE, MARYLAND		FATHER'S RELIGION METHODIST		MOTHER'S RELIGION METHODIST		FATHER'S MARRIAGE MARRIED		MOTHER'S MARRIAGE MARRIED		FATHER'S EDUCATION HIGH SCHOOL		MOTHER'S EDUCATION HIGH SCHOOL		FATHER'S OCCUPATION LABORER		MOTHER'S OCCUPATION HOUSEWIFE		FATHER'S CAUSE OF DEATH HEART DISEASE		MOTHER'S CAUSE OF DEATH HEART DISEASE		FATHER'S MANNER OF DEATH NATURAL		MOTHER'S MANNER OF DEATH NATURAL		FATHER'S PLACE OF DEATH HOME		MOTHER'S PLACE OF DEATH HOME		FATHER'S DATE OF DEATH OCT 26 1956		MOTHER'S DATE OF DEATH OCT 26 1956		FATHER'S TIME OF DEATH 10:30 AM		MOTHER'S TIME OF DEATH 10:30 AM		FATHER'S SIGNATURE (None)		MOTHER'S SIGNATURE (None)		FATHER'S PHYSICIAN (None)		MOTHER'S PHYSICIAN (None)		FATHER'S CORONER (None)		MOTHER'S CORONER (None)		FATHER'S REGISTRAR (None)		MOTHER'S REGISTRAR (None)		FATHER'S CLERK (None)		MOTHER'S CLERK (None)	

BUREAU V. S.

OCT 26 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10800

CERTIFICATE OF DEATH

Reg. Dist. No. 10817 322

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Md.</u> COUNTY <u>Somerset</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>16 days</u>		TOWN <u>Seal Island</u>		TOWN <u>Seal Island</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>none</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Adolphus</u> <u>Walters</u>				<u>October 20</u> - <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Aug 6 - 1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Seal Island Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HAMILTON WALTERS</u>				14. MOTHER'S MAIDEN NAME <u>MELISSA WEBSTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, blank) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Daughter Bette</u> <u>1300 Blockworth</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/4</u> , 19 <u>56</u> , to <u>10/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-20</u> , 19 <u>56</u> , and that death occurred at <u>6:15 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William R. Eccles</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>10-22-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct 23 - 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		LOCATION (City, town, or county) (State) <u>Seal Island Md.</u>	
24. REC'D. BY REGISTRAR <u>10/25/56</u>		REGISTRAR'S SIGNATURE <u>Lela M. Heasley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Webster</u>		ADDRESS <u>Seal Island Md.</u>	

CERTIFICATE OF DEATH

Form 10-1-1954

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)
 3. AGE (Years, Months, Days)
 4. DATE OF BIRTH (Month, Day, Year)
 5. PLACE OF BIRTH (City, State, Country)

6. MARRIAGE (Married, Single, Widowed, Divorced)

7. OCCUPATION (Print or Write)

8. CAUSE OF DEATH (Print or Write)

9. PLACE OF DEATH (Print or Write)

10. TIME OF DEATH (Print or Write)

11. SIGNATURE OF PHYSICIAN (Print or Write)

12. SIGNATURE OF REGISTRAR (Print or Write)

13. SIGNATURE OF WITNESS (Print or Write)

14. SIGNATURE OF DECEASED (Print or Write)

15. SIGNATURE OF NEXT OF KIN (Print or Write)

16. SIGNATURE OF CLERGYMAN (Print or Write)

17. SIGNATURE OF BURIAL OFFICIAL (Print or Write)

18. SIGNATURE OF FUNERAL HOME (Print or Write)

19. SIGNATURE OF CEMETERY (Print or Write)

20. SIGNATURE OF OTHER (Print or Write)

21. SIGNATURE OF OTHER (Print or Write)

22. SIGNATURE OF OTHER (Print or Write)

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49. SIGNATURE OF OTHER (Print or Write)

50. SIGNATURE OF OTHER (Print or Write)

51. SIGNATURE OF OTHER (Print or Write)

52. SIGNATURE OF OTHER (Print or Write)

53. SIGNATURE OF OTHER (Print or Write)

54. SIGNATURE OF OTHER (Print or Write)

55. SIGNATURE OF OTHER (Print or Write)

56. SIGNATURE OF OTHER (Print or Write)

57. SIGNATURE OF OTHER (Print or Write)

58. SIGNATURE OF OTHER (Print or Write)

BUREAU V. 3

OCT 29 1956

RECEIVED

2000-10-29

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10818
337

10801

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY in 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital				d. STREET ADDRESS R.D. # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ERNEST Last WILLIAMS				4. DATE OF DEATH Month OCT. Day 16 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1896		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 4 Days 6	IF UNDER 24 HRS. Hours 6 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Work - Construction - Laborer			10b. KIND OF BUSINESS OR INDUSTRY Shad Point, Maryland		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Fredrick A. Williams				14. MOTHER'S MAIDEN NAME Ida M. Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT (Address) Mrs. Iva M. Williams (Wife) R.D. # 1 Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mesenteric thrombosis DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 23 hrs yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. Earl L. Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 18 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20, 1956	22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery - Shad Point - R.D. # Salisbury, Md.		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 19 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File-pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Jones		Male		35		White		June 10, 1956		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Security No.	
Heart Disease		Natural		Teacher		High School		Married		123-45-6789	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home	
J. L. Thompson		W. H. Smith		M. A. Brown		C. D. White		R. E. Green		F. G. Black	

RECEIVED
 OCT 19 1956
 BUREAU V. B.

CERTIFICATE OF DEATH

Reg. Dist. No.

10802

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b II weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Convalescent Home				d. STREET ADDRESS Princess Anne			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Franklin Middle A. Willing Last				4. DATE OF DEATH Month Oct. Day 26 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1859	
9. AGE (In years last birthday) yrs. 97		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired waterman		10b. KIND OF BUSINESS OR INDUSTRY seafood		11. BIRTHPLACE (State or foreign country) Bivalve, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Willing				14. MOTHER'S MAIDEN NAME Susan Larmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs Mark White Princess Anne, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/22 , 19 56 , to 10/26 , 19 56 , that I last saw the deceased alive on 10/26 , 19 56 , and that death occurred at 7 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Carl M. Brinkley				ADDRESS (Street, city or town, state) Salisbury, Md.		DATE SIGNED 10/27/56	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-28-1956		22c. NAME OF CEMETERY OR CREMATORY Bivalve Cemetery		22d. LOCATION (City, town, or county) (State) Bivalve, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leslie R. Wilson				ADDRESS Princess Anne, Maryland		24a. REC'D BY REGISTRAR 10/30/56	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10820

10803 CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place) <u>1 DAY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BERLIN</u>		<u>29x2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL Hospital</u>				STREET ADDRESS (If rural give location) <u>R.F.D. TAYLORVILLE</u>			
3. NAME OF DECEASED (Type or Print) <u>ALICE</u> (First) <u>GERTRUDE</u> (Middle) <u>WYATT</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>October 24</u> 19 <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>MAR. 10, 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SNOW HILL, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>SARAH WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>MR JAMES R. WYATT, BERLIN MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>420.0 Arterio-sclerotic Heart Disease</u>						<u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on..... <u>10-24</u>, 19..... <u>56</u>, and that death occurred at..... <u>1:30 P.</u>M, from the causes and on the date stated above. SIGNATURE <u>William R. Brown</u> M.D. ADDRESS (Street, city, town, state) <u>Salisbury, Md</u> DATE SIGNED <u>10-24-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10/28/56</u>		NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>		LOCATION (City, town, or county) (State) <u>BERLIN (RFD) MD</u>	
24. REC'D BY REGISTRAR DATE <u>10/26/56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>		ADDRESS <u>Berlin Md</u>	

